**SUMMARY OF MATERIAL MODIFICATIONS TO THE FLEXIBLE BENEFITS PLAN**

***This document summarizes important changes to your Flexible Benefits Plan. If you have any questions regarding the changes summarized in this Summary of Material Modifications ("SMM"), you should contact the Benefits Division of the State Personnel Department or the third party administrator of the State's Flexible Spending Plan. You should keep a copy of this SMM with your Summary Plan Description for future reference.***

Effective December 31, 2005, the Employer has added the following language to the definition of Eligible Medical Expenses described in the Summary Plan Description:

**I. Limited-Scope Reimbursement Provision**

*If you currently maintain or wish to establish a personal Health Savings Account (Limited Reimbursement Option)*

According to rules set forth in Code Section 223 (applicable to Health Savings Accounts), a Health FSA participant (and any covered dependents) will not be able to make/receive tax favored contributions to a Code Section 223 HSA unless the scope of expenses eligible for reimbursement under the Health FSA is limited to the following expenses (to the extent such expenses constitute "medical care" as defined in Code Section 213(d)):

(i) Services or treatments for dental care (excluding premiums)

(ii) Services or treatments for vision care (excluding premiums)

(iii) Services for preventive care. Preventive care is defined in accordance with applicable rules and regulations but is essentially limited to diagnostic procedures and services or treatments taken prevent the onset of a disease or condition that is imminently possible. This may include any prescription or over the counter drugs to the extent such drugs are taken by an eligible individual (a) to delay or prevent the onset of symptoms of a condition for which symptoms have not yet manifested themselves (b) to prevent the recurrence of a condition from which the eligible individual has recovered or (c) as part of a preventive care treatment program (e.g., a smoking cessation or weight loss program). Preventive care does not include services or treatments that treat an existing condition.

(iv) Eligible medical expenses incurred after the "minimum deductible" has been satisfied. The applicable minimum deductible under this plan is conditioned on your family status. If you are single, the minimum deductible equals your annual deductible under the Employer's qualifying high deductible health plan (as designated by the Employer) in which you are a participant. If you have Eligible Dependents covered under the health FSA, the minimum deductible is the greater of the annual deductible under the Employer's qualifying high deductible health plan or the minimum statutory deductible amount applicable to family level coverage as set forth in Code Section 223(b) (adjusted for inflation). The statutory minimum deductible amount applicable to family coverage (as set forth in Code Section 223) for 2006 is $2,100.

You may elect to limit reimbursement under this Health FSA as set forth above. You must make your election to limit reimbursement during the Initial and/or Annual Enrollment Period. If you currently participate in an HSA, you are not eligible to participate in this Health FSA unless you limit the scope of reimbursement as described above.

## II. Grace Period Provision

The Flexible Benefits Plan is hereby amended to provide for a grace period immediately following the end of each plan year. The grace period will extend for two months and fifteen days past the end of each plan year. The grace period applies to all participants in the cafeteria plan, except as qualifed below. Expenses for qualified benefits that are incurred during the grace period will be paid or reimbursed first from benefits or contributions that remain unused at the end of the prior plan year. Any unused amounts from the prior plan year that are not used to reimburse expenses by the end of the grace period remain subject to the "use it or lose it" rule and must be forfeited.

All claims for benefits that are incurred during the plan year and during the grace period must be submitted no later than 90 days after the end of the grace period.

Plan year 2005 Transitional Relief:
The Flexible Benefits Plan will not provide grace period coverage for the 2005 flexible benefits plan year to an individual who participates in the employer's IRS-defined High Deductible Healthcare Plan (HDHP) in 2006.

Plan years 2006 and after:
For those individuals participating in the employer's HDHP Plan, reimburseable expenses during the grace period applicable to the previous Flexible Benefits Plan year will be restricted to those expenses listed within this amendment's "Limited Scope Reimbursement" provision, as set out above.